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From the Editor's desk

By Kamaldeep Bhui

Trials , tribulations, mind and mechanism

Cost and innovation

UK investment in health (public and private) is falling, from 8% in 2009, to 6.6% by 2021.[1] Current expectations of the NHS, to provide comprehensive, modernised, and scientifically founded care have risen alongside greater needs of a growing population living with chronic illnesses. In fact, global efforts to improve health are challenged by similar issues, and most people around the globe are neither seeing nor do they expect comprehensive health coverage. Many countries still do not have appropriate policy and legislation. The current strains on health provision in the UK and other higher-income countries demand actions that perhaps would only have been previously been considered for lower-income countries where, by comparison, there is grossly insufficient investment (see editorial by Sashidharan *et al*, pp. 3–5); so task shifting and community development innovations from low-income countries are proposed as alternatives to high-quality healthcare in high-income countries. The job of government has become to contain and offset costs to the state by seeking a range of alternative providers, and by driving down the costs of existing provision.

The dispute between the health secretary and junior doctors in England spiralled into impasse, with junior doctors taking industrial action and, for the first time, withdrawing emergency and routine care; the health secretary was unable to acknowledge the failings of the scientific case that excessive weekend deaths were related to a shortage of doctors working at weekends.[2] Driving down costs of healthcare was the prime motivation of government. Patel and colleagues (pp. 29–34) show in one provider that weekend deaths are actually uncommon in psychiatric services, and less likely than during the week, yet whatever agreement is reached it is likely to impact on all junior doctors, irrespective of specialty.

Social context and deprivation

Another approach is to provide early and more effective interventions that are less expensive than existing interventions. Freeman and colleagues (pp. 62–67) present a remarkable taster of what virtual reality cognitive–behavioural therapy (CBT) might achieve in shifting delusional thinking. Patients receiving virtual CBT fare better than those receiving virtual exposure, offering a potential treatment to many more people around the world, as long as there are adequate internet connections and the costs of the intervention are acceptable. Perhaps adaptations will be needed for specific country, cultural and economic contexts. Mindfulness-based CBT is also effective for anxiety symptoms (see Wong *et al*, pp. 68–75), and might be developed as a virtual reality intervention. A risk associated with any exciting new interventions is the activation of the inverse care law, whereby those in most need are less able to access or make use of the intervention.

Improving access to psychological interventions (IAPT) is an ambitious CBT programme that was rolled out across England, offering early psychological interventions to those with common anxiety and depressive illnesses, in order to promptly restore function and return to work. Delgadillo *et al*[3] has shown that IAPT services seem less effective in areas of deprivation, and that measures of success do not take account of deprivation; indeed, investment does not reflect area need, suggesting basic flaws in the formulae for funding allocation. Supported employment rather than traditional vocational support has greater success for people with psychosis (Modini *et al*, pp. 14–22), and this finding was robust to socio-economic variation and poor growth in gross domestic product. Given the recession, and reductions in NHS spend, there are growing concerns about the deterioration and quality of care of in-patient environments that provide treatment for the most ill patients (Csipke *et al*, pp. 35–39), again requiring more thought about how to better use existing resources, rather than anticipate further investment.

The power of a negative finding

Shared decision making seems to improve empowerment of patients, and may reduce detentions, although there is little effect on quality of the therapeutic relationship (Stovell *et al*, pp. 23–28). Negative findings are raising concern, given how the length of time and cost involved in mounting the research, especially clinical trials. Many randomised controlled trials are launched on the back of early stage feasibility and pilot studies, and yet despite showing great promise, appear to display negative findings. Crawford and colleagues (pp. 6–8) discuss the challenge more generally but emphasise this failing is especially common for studies of interventions for mental illness, commending parallel process evaluations of trials (for example, see Priebe *et al*, pp. 54–61, on body psychotherapy). The recommendations include lengthier and more nuanced evaluations prior to pursuing trial designs It may be that trial designs are not suited to complex interventions for mental healthcare;[4] indeed, there is now a trend emerging that the academic pipeline is insufficiently efficient for real-world quality improvement in services, giving way to experimentation adapted for local contexts, and then scalability is assessed, subverting and replacing the pipeline of research and development.[5]

Mechanistic: social and bio-physiological

O'Connor *et al* (pp. 76–83) targeted psychophysiological processes in the generation of tics, and showed benefits, giving an example of a simple idea applied to the mechanism of action rather than treating tics. Larger trials will be needed; or will they, if experimentation should proceed straight to scaling and testing? Similarly, Thompson *et al*'s intriguing study (pp. 40–47) shows how communication styles can improve therapeutic relationships; in support of this emphasising the role of social processes and communication; consistent with this emphasis, negative emotion and psychosocial factors are major influences on recovery (Law *et al*, pp. 48–53). Patients enter the socially defined sick role, and find ways of leaving this role through societal and health system efforts. Ventriglio and colleagues (pp. 1–2) plead for more emphasis on the psychological and the social aspects of care for patients, the term itself provoking strong opinions and a flux in societal and professional attitudes (Christmas and Sweeney debate this issue, pp. 9–13). The Royal College of Psychiatrists has elected to choose the term patients, yet the debate shows the strength of feeling and that even democratic systems may disempower a minority who are not permitted to define their identity.

1 Appleby J. How does NHS spending compare with health spend internationally. The King's Fund (http://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally), 2016.

2 Wise J. The weekend effect-how strong is the evidence? *BMJ* 2016; **353**: i2781.

3 Delgadillo J, Asaria M, Ali S, Gilbody S. On poverty, politics and psychology: the socioeconomic gradient of mental healthcare utilisation and outcomes. *Br J Psychiatry* 19 Nov 2016 (doi: 10.1192/bjp.bp.115.171017).

4 Slade, M. Priebe, S. Are randomised controlled trials the only gold that glitters? *Br J Psychiatry* 2001; **179**: 286–7.

5 Schrage M. R&D meets E&S (Experiment & Scale). MIT Sloan Management Review (http://sloanreview.mit.edu/article/rd-meet-es-experiment-scale/), 2016.

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